The 2009 Physician Quality Reporting Initiative (PQRI)

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This booklet is a compilation of the Centers for Medicare & Medicaid Services' (CMS') various educational resources relevant to the 2009 Physician Quality Reporting Initiative (PQRI). The Tax Relief and Health Care Act of 2006 (TRHCA) authorized a financial incentive for eligible professionals to participate in a **voluntary** quality reporting program in 2007. CMS titled this program the Physician Quality Reporting Initiative (PQRI). The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) authorized a financial incentive for participation in the program in 2008, as well as alternative reporting periods and alternative criteria for satisfactorily reporting quality measures for the 2008 PQRI. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made PQRI a permanent program and authorized incentive payments for 2009.

What is the Physician Quality Reporting Initiative (PQRI)?

PQRI is a voluntary individual reporting program that provides an incentive payment to identified eligible professionals who satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (includes Railroad Retirement Board and Medicare Secondary Payer). Medicare Part C Medicare Advantage (MA) patients are not included in claims-based reporting of measures or measures groups, but may be included in registry-based reporting in certain circumstances.

What are Important Changes for the 2009 PQRI?

- In 2009, the definition of "eligible professional" has been expanded to include qualified audiologists.
- Eligible professionals who satisfactorily report at least three applicable quality measures shall be paid an incentive of 2.0 percent of estimated allowable charges submitted not later than two months after the end of the reporting period for 2009 PQRI quality measures. This is an increase of 0.5 percent from the incentive amount authorized for the 2008 PQRI.
- If fewer than three PQRI quality measures apply to an eligible professional, he or she may still qualify for the 2.0 percent PQRI incentive payment by satisfactorily submitting quality-data codes (QDCs) for all applicable measures through claims submission. However, eligible professionals who satisfactorily submit QDCs for fewer than three PQRI measures will be subject to a measure-applicability validation (MAV) process to determine whether they should have submitted QDCs for additional measures.
- The MAV process will be applied to determine whether QDCs for additional measures should have been submitted when eligible professionals satisfactorily submit QDCs for fewer than three PQRI measures. MAV consists of a two-step process: (1) a "clinical relation" test, and (2) a "minimum threshold" test. Those who fail the validation process will not earn the PQRI incentive payment for 2009. A detailed document describing how MAV will be applied for the 2009 PQRI will be available as a downloadable document under the Analysis and Payment section at *http://www.cms.hhs.gov/PQRI* on the CMS website.

- CMS will conduct another self-nomination process for registries so additional registries can potentially be approved for submitting quality measures data for the 2009 PQRI. Registries qualified to submit data on behalf of their eligible professionals in 2008 are not required to self-nominate again for 2009 unless they are unsuccessful at submitting 2008 data by March 31, 2009. The list of qualified registries for the 2009 PQRI is available as a downloadable document under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website.
- For 2009 PQRI submitted data, CMS plans to post the names of individual eligible professionals who satisfactorily report quality measures for the 2009 PQRI following completion of 2009 incentive payments.

What are the 2009 PQRI Individual Quality Measures?

The final number of 2009 PQRI quality measures is 153. This total includes 52 new measures. Whereas all 2008 PQRI quality measures were reportable through claims submission or through a qualified PQRI registry, a subset of the 2009 PQRI quality measures is reportable only through registries.

Appendix 1 lists 18 measures removed from the 2008 PQRI measures for 2009.

Appendix 2 identifies the new 2009 PQRI measures.

Appendix 3 identifies 18 measures reportable only through registries in 2009.

Note: The detailed measure specifications for the 2008 PQRI quality measures selected for the 2009 PQRI may have been updated or modified during the National Quality Forum (NQF) endorsement process or for other reasons prior to 2009. The 2009 PQRI quality measure specifications for any given quality measure may, therefore, be different from specifications for the same quality measure used for 2008. Specifications for all 2009 PQRI quality measures, whether or not included in the 2008 PQRI, must be obtained from the 2009 PQRI Quality Measures Specifications Manual for 2009 PQRI quality measures, which is available as a downloadable document under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website.

What are the 2009 PQRI Measures Groups?

For 2009, there are seven measures groups.

Appendix 4 includes measures numbers, titles, and sources for each of the measures groups: 1) Diabetes Mellitus, 2) Chronic Kidney Disease (CKD), 3) Preventive Care, 4) Rheumatoid Arthritis, 5) Coronary Artery Bypass Graft (CABG) Surgery, 6) Perioperative Care, and 7) Back Pain.

The first three measures groups were retained from last year; however, except for the Preventive Care Measures Group, the measures selected for inclusion in these measures groups are different from the measures that were included in the 2008 measures groups. Please note that the End Stage Renal Disease (ESRD) Measures Group is removed from PQRI for 2009.

In addition, measures groups specifications are different from those specifications for individually reported measures that form the group. Therefore, the specifications and reporting instructions for the 2009 PQRI measures groups are provided separately in the 2009 PQRI Measures Groups Specifications Manual available as a downloadable document under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website. Please note that new for 2009, if **all** quality actions for the applicable measures in a measures group have been performed for the patient, **one G-code** may be reported in lieu of the individual QDCs for each of the measures within the group.

Note: The measures in the Back Pain Measures Group are reportable solely as a measures group and not as individual quality measures. In addition, some of the measures in the CABG Surgery Measures Group are reportable only through a qualified PQRI registry. Therefore, the CABG Surgery Measures Group is reportable only through a qualified PQRI registry and is not reportable through claims submission.

What are the 2009 PQRI Reporting Options and Criteria for Satisfactory Reporting?

In total, there are nine reporting options or ways in which an eligible professional can satisfactorily report for the 2009 PQRI. Although there are multiple reporting options for satisfactory reporting, an eligible professional only needs to satisfactorily report under one option to qualify for the 2.0 percent PQRI incentive payment for the applicable reporting period.

Note: Although the number of reporting options remains the same as in the 2008 PQRI, there are some differences between the 2008 PQRI reporting criteria and the 2009 reporting criteria. The criteria that will be used to determine whether an eligible professional satisfactorily reports for the 2009 PQRI are summarized in Tables 1 through 4 below.

Table 1: Criteria for Claims-based Reporting of Individual Measures

Reporting Criteria	Reporting Period
At least 3 PQRI measures or 1-2 measures if less than 3 apply to the eligible professional, for 80 % of applicable Medicare Part B FFS patients of each eligible professional.	January 1, 2009 - December 31, 2009

Table 2: Criteria for Claims-based Reporting of Measures Groups

Reporting Criteria	Reporting Period
One measures group for 30 consecutive Medicare Part B FFS patients of each eligible professional.	January 1, 2009 - December 31, 2009

Table 2: Criteria for Claims-based Reporting of Measures Groups (continued)

Reporting Criteria	Reporting Period
One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 30 patients during the reporting period).	January 1, 2009 - December 31, 2009
One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period).	July 1, 2009 - December 31, 2009

Table 3: Criteria for Registry-based Reporting of Individual Measures

Reporting Criteria	Reporting Period
At least 3 PQRI measures for 80% of applicable Medicare Part B FFS patients of each eligible professional.	January 1, 2009 - December 31, 2009
At least 3 PQRI measures for 80% of applicable Medicare Part B FFS patients of each eligible professional.	July 1, 2009 - December 31, 2009

Table 4: Criteria for Registry-based Reporting of Measures Groups

Reporting Criteria	Reporting Period
One measures group for 30 consecutive patients of each eligible professional. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients.	January 1, 2009 - December 31, 2009
One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 30 patients during the reporting period).	January 1, 2009 - December 31, 2009
One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period).	July 1, 2009 - December 31, 2009

How do Eligible Professionals Satisfactorily Report 2009 PQRI Measures?

Although there is no requirement to register prior to submitting the data, there are some preparatory steps that eligible professionals should take prior to undertaking PQRI reporting. The following describes preparatory steps and helpful tips for eligible professionals and their billing staff.

It is recommended that eligible professionals and their office staff establish an office workflow that allows accurate identification of each denominator-eligible Part B Medicare claim (i.e., claims for services listed in the denominator coding section of each measure's specifications). The workflow process should also ensure that these claims are accurately coded using PQRI QDCs found in the numerator section of the measure specification. The workflow process should also include discussing and coordinating with the billing software vendor/clearinghouse to ensure that they can report all PQRI codes accurately on behalf of the eligible professional. Consider implementing an edit on the billing software to ensure that all eligible claims are flagged for PQRI QDCs for each measure selected to report prior to submitting claims to the carrier/Medicare Administrative Contractor (MAC).

How to Get Started

STEP 1:

Determine eligibility to participate. A list of professionals who are eligible and able to participate in PQRI is available at *http://www.cms.gov/PQRI/Downloads/EligibleProfessionals.pdf* on the CMS website. Read this list carefully, as not all entities are considered eligible professionals.

STEP 2:

Determine which PQRI reporting option(s) best fits the practice (claims-based or registry-based for individual measures or measures groups) as well as the PQRI reporting period (6-months or 12-months), which varies with the reporting option. Refer to the 2009 PQRI Participation Decision Tree in Appendix C of the 2009 PQRI Implementation Guide, which is available as a downloadable document under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website.

STEP 3:

Review the 2009 PQRI Measures List, which is available as a downloadable document under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website, and determine which PQRI measures apply.

Eligible professionals who choose to report on individual measures need to select at least three measures to report on to be able to qualify to earn a PQRI incentive payment for 2009.

Eligible professionals who choose to report measures groups need to select at least one measures group to report to be able to qualify to earn a PQRI incentive payment for 2009.

Eligible professionals who have already been participating in PQRI are not required to select new/different measures for 2009. Please note that all PQRI measure specifications are updated and posted prior to the beginning of each program year, so eligible professionals will need to review them for any revisions.

STEP 4:

Individual PQRI Measures Reporting

Once measures are selected (at least three), carefully review the following documents:

1. 2009 PQRI Quality Measures Specifications Manual and Release Notes for claims-based or registry-based reporting of individual measures. The entire manual does not need to be printed; just print the few pages that describe reporting and coding specifications for the selected three measures.
2. 2009 PQRI Implementation Guide, which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in CMS-1500 format.

Both documents can be found as downloadable documents under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website.

In the specifications and reporting instructions, note that each of the measures has a QDC (a Current Procedural Terminology [CPT] II code or G-code) associated with it and several CPT II modifiers: generally 1P, 2P, and 3P. To qualify for the incentive, the correct QDC will need to be reported on at least 80 percent of the claims that are eligible for each selected measure. A claim is "eligible" when the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis and the CPT I service codes match the diagnosis and CPT I codes listed for the measure denominator.

Also note that each measure has a reporting frequency or timeframe requirement for each eligible patient seen during the reporting period for each individual eligible professional (National Provider Identifier [NPI]). The reporting frequency (i.e., report each visit, once during the reporting period, each episode, etc.) is found in the Instructions section of each measure specification. Ensure that all members of the team understand and capture this information in the clinical record to facilitate reporting.

Or, as an alternative to reporting on at least three individual measures, eligible professionals can select to report one or more measures groups.

PQRI Measures Groups Reporting

Once the measures group(s) is selected, carefully review the following documents:

1. 2009 PQRI Measures Groups Specifications Manual for claims-based or registry-based reporting of measures groups. The entire manual does not need to be printed; just print the few pages that have to do with the detailed coding specifications for the selected measures group(s). Note that the specifications for a measures group are different from those for individual measures. Be sure to use the correct specifications.

2. Getting Started with 2009 PQRI Reporting of Measures Groups – This is the implementation guide for reporting measures groups.
3. 2009 PQRI Tip Sheet: PQRI Made Simple For Reporting the Preventive Care Measures Group – This tip sheet provides a useful worksheet to keep track of each patient reported when using the 30 consecutive patient sample method for a measures group.

These three documents are available as downloadable documents under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website.

How are the 2009 Patient-Level Measures Reported?

Each measure specified in the 2009 PQRI includes a reporting frequency requirement, located in the Instructions section, for each denominator-eligible patient seen during the claims-based reporting period (January 1 - December 31, 2009). Measure specification instructions limit the frequency of reporting necessary in certain circumstances (such as for patients with chronic illness for whom a particular process of care is provided periodically).

PQRI measures, including patient-level measure(s), may be reported for the same patient by multiple eligible professionals practicing under the same Tax Identification Number (TIN). If a patient sees multiple eligible professionals during the reporting the period, that patient can be counted for each individual NPI reporting if the patient encounter(s) meet denominator inclusion.

The following is an example of two eligible professional NPIs billing under the same TIN, who are intending to report PQRI Measure #5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).

Reporting Example

Provider A sees a patient on February 2, 2009 and prescribes an ACE inhibitor and reports the appropriate QDCs for Measure #5. Provider B sees the same patient at an encounter on July 16, 2009 and verifies that the patient has been prescribed and is currently taking an ACE inhibitor. Provider B must also report the appropriate QDCs for the patient at the July encounter to receive credit for reporting Measure #5.

Table 5 is a subset of the 2009 measures for which the reporting frequency is a minimum of once per reporting period per each individual eligible professional (NPI). In other words, these are considered patient-level or patient-process measures.

Table 5: Patient-level or Patient-process Measures

Measure Number	Measure Title
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
41	Osteoporosis: Pharmacologic Therapy
47	Advance Care Plan
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
53	Asthma: Pharmacologic Therapy
64	Asthma: Asthma Assessment
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

Table 5: Patient-level or Patient-process Measures (continued)

Measure Number	Measure Title
69	Multiple Myeloma: Treatment with Bisphosphonates
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD
83	Hepatitis C: Testing for Chronic Hepatitis C - Confirmation of Hepatitis C Viremia
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment
85	Hepatitis C: HCV Genotype Testing Prior to Treatment
86	Hepatitis C: Antiviral Treatment Prescribed
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy
106	Major Depressive Disorder (MDD): Diagnostic Evaluation
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD)Therapy
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older
112	Preventive Care and Screening: Screening Mammography
113	Preventive Care and Screening: Colorectal Cancer Screening
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use
115	Preventive Care and Screening: Advising Smokers to Quit
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)

Table 5: Patient-level or Patient-process Measures (continued)

Measure Number	Measure Title
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
134	Screening for Clinical Depression and Follow-Up Plan
135	Chronic Kidney Disease (CKD): Influenza Immunization
136	Melanoma: Follow-Up Aspects of Care
137	Melanoma: Continuity of Care – Recall System
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula
154	Falls: Risk Assessment
155	Falls: Plan of Care
156	Oncology: Radiation Dose Limits to Normal Tissues
163	Diabetes Mellitus: Foot Exam
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening
176	Rheumatoid Arthritis (RA): Tuberculosis Screening
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
178	Rheumatoid Arthritis (RA): Functional Status Assessment
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
180	Rheumatoid Arthritis (RA): Glucocorticoid Management
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV
186	Wound Care: Use of Compression System in Patients with Venous Ulcers

Getting Started with 2009 PQRI Reporting of Measures Groups

Measures groups include reporting on a group of clinically-related measures either through claims-based or registry-based submission mechanisms. Seven measures groups have been created for the 2009 PQRI: 1) Diabetes Mellitus, 2) Chronic Kidney Disease (CKD), 3) Preventive Care, 4) Coronary Artery Bypass Graft (CABG), 5) Rheumatoid Arthritis, 6) Perioperative Care, and 7) Back Pain.

Eligible professionals can choose to participate under more than one 2009 PQRI reporting option. Eligible professionals who satisfactorily report under more than one reporting option will receive a maximum of one incentive payment, which will be equivalent to 2.0 percent of the Medicare Physician Fee Schedule (PFS) allowed charges for all covered professional services furnished during the longest reporting period for which he or she has satisfied the reporting criteria.

The 2009 PQRI Measures Groups reporting alternative is available for the 12-month reporting period (January 1 through December 31, 2009) or the 6-month reporting period (July 1 through December 31, 2009). Individual participating eligible professionals who satisfactorily report under measures groups may receive an incentive payment equivalent to 2.0 percent of the total allowed PFS charges for covered professional services furnished to patients enrolled in Medicare Part B FFS during either the January 1 through December 31, 2009 reporting period or the July 1 through December 31, 2009 reporting period. Below is a participation strategy and information to facilitate satisfactory reporting by each eligible professional who wishes to pursue this alternative.

The 2009 PQRI Measures Groups Specifications Manual, which can be found under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI*, contains detailed descriptions for each quality measure within each measures group. Denominator coding has been modified from the original measure as specified by the measure developer to allow for implementation as a measures group. To get started, review the 2009 PQRI Measures Groups Specifications Manual to determine if a particular measures group is applicable to Medicare services the practice provides.

Measures Groups Participation Strategy

1. Plan and implement processes within the practice to ensure satisfactory reporting of measures groups.
2. Become familiar with the methods for satisfactory reporting of measures groups. The two reporting methods for measures groups are:

   Consecutive Patient Sample Method: For claims-based submissions, 30 consecutive Medicare Part B FFS enrolled patients meeting patient sample criteria (see Table 6) for the measures group. **Counting will begin on the date of service that the measures group-specific G-code is submitted.** For example, an eligible professional can indicate intent to begin reporting the Diabetes Mellitus Measures Group by submitting G8485 on the first patient claim in the series of consecutive diabetic patients. For registry-based submissions, an eligible professional must report on all applicable measures within the selected measures group for a minimum

of 30 consecutive patients (which may include non-Medicare Part B FFS patients) who meet patient sample criteria for the measures group. For both claims-based and registry-based submissions, all **applicable** measures within the group must be reported at least once during the reporting period (January 1 through December 31, 2009) for each of the 30 consecutive patients.

OR

80 Percent Patient Sample Method: All Medicare Part B FFS enrolled patients seen during the reporting period (either January 1 through December 31, 2009 **or** July 1 through December 31, 2009) and meeting patient sample criteria (see Table 6) for the measures group. For claims-based submissions, PQRI analysis will be initiated when the measures group-specific G-code is submitted on a claim, but **all** claims meeting patient sample criteria in the selected reporting period will be included, regardless of the date of service the measures group-specific G-code is submitted. A minimum of 80 percent of this patient sample must be reported for all applicable measures within the group according to the individual measures group reporting instructions. For the 12-month reporting period, a minimum of 30 patients must meet the measures group patient sample criteria to report satisfactorily. For the 6-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria to report satisfactorily.

3. Determine the patient sample based on the patient sample criteria, which is used for both the Consecutive Patient Sample Method and the 80 Percent Patient Sample Method. Table 6 contains patient sample criteria (common codes) that will qualify an eligible professional's patient for inclusion in the measures group analysis. For claims-based submissions, claims must contain a line-item ICD-9-CM diagnosis code (where applicable) accompanied by a specific CPT patient encounter code. All diagnoses included on the base claim are considered in PQRI analysis.

Table 6: Patient Sample Criteria

Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Diabetes Mellitus 18-75 years	97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Chronic Kidney Disease (CKD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245	585.4, 585.5
Preventive Care 50 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	
Coronary Artery Bypass Graft (CABG) 18 years and older	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536	
Rheumatoid Arthritis 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456	714.0, 714.1, 714.2, 714.81

Table 6: Patient Sample Criteria (continued)

Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Perioperative Care 18 years and older	19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 44005, 44010, 44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49215, 50320, 50340, 50360, 50365, 50370, 50380, 60521, 60522, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276	

Table 6: Patient Sample Criteria (continued)

Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Back Pain 18-79 years	**Diagnosis codes with CPT codes:** 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 **OR** 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200	**Diagnosis codes for CPT 9XXXX codes:** 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

4. For claims-based submissions, initiate reporting of measures groups by using the measures group-specific G-codes listed below. To indicate intent to begin reporting a measures group, submit a measures group-specific G-code on a patient claim. It is not necessary to submit the measures group-specific G-code on more than one claim. If the G-code for a given group is submitted multiple times during the reporting period, only the submission with the earliest date of service will be included in the PQRI analysis; subsequent submissions of that code will be ignored. It is not necessary to submit the measures group-specific G-code for registry-based submissions.

   G8485: I intend to report the Diabetes Mellitus Measures Group

   G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group

   G8486: I intend to report the Preventive Care Measures Group

   G8490: I intend to report the Rheumatoid Arthritis Measures Group

G8492: I intend to report the Perioperative Care Measures Group

G8493: I intend to report the Back Pain Measures Group

Measures group-specific G-code line items on the claim must be complete, including accurate coding, date of service, diagnosis pointer, and individual NPI in the rendering provider field. The diagnosis pointer field on the claim links the patient diagnosis to the service line. A G-code specific to a condition-specific measures group (e.g., Diabetes Mellitus Measures Group) should be linked to the diagnosis for the condition to which it pertains; a G-code for the Preventive Care Measures Group may be linked to any diagnosis on the claim.

Measures group-specific G-code line items should be submitted with a charge of zero dollars ($0.00). Measures group-specific G-code line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. An eligible professional should check his or her Remittance Advice ("Explanation of Benefits" or "EOB") for a denial code (e.g., N365) for the measures group-specific G-code, confirming the code passed through his or her local carrier/MAC to the National Claims History (NCH) file. The N365 denial code indicates that the line item is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of measures group-specific G-codes. The N365 remark code does **NOT** indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report.

5. For patients to whom measures groups apply, report all applicable individual measures for the measure group. Report QDCs as instructed in the 2009 PQRI Measures Groups Specifications Manual on all applicable measures within the measures group for each patient included in the sample population for each individual eligible professional. For claims-based submissions, an eligible professional may choose to submit QDCs either on a current claim or on a claim representing a subsequent visit, particularly if the quality action has changed. For example, a new laboratory value may be available at a subsequent visit. Only one instance of reporting for each patient included in the sample population will be used when calculating reporting and performance rates for each measure within a group.

   If all quality actions for the applicable measures in the measures group have been performed for the patient, one G-code may be reported in lieu of the individual QDCs for each of the measures within the group. Refer to the 2009 PQRI Measures Groups Specifications Manual for detailed instructions to report QDCs for each of the measures group under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website.

   An eligible professional is only required to report QDCs on those individual measures in the measures group that meet the criteria (age or gender) according to the 2009 PQRI Measures Groups Specifications Manual. For example, if an eligible professional is reporting the Preventive Care Measures Group for a 52 year old female patient, only 6 measures out of 9 apply (see the Preventive Measures Group Demographic Criteria in Table 7).

Table 7: Preventive Measures Group Demographic Criteria

Age	Measures for Male Patients	Measures for Female Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 114, 115, 128	110, 112, 113, 114, 115, 128
65-69 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 112, 113, 114, 115, 128
70-80 years	39, 48, 110, 111, 112, 113, 114, 115, 128	39, 48, 110, 111, 113, 114, 115, 128
<81	110, 111, 114, 115, 128	39, 48, 110, 111, 114, 115, 128

Reporting Measures Groups - Common Clinical Scenarios

The following clinical scenarios and Tables 8 through 13 are offered as examples describing the quality data that should be reported on claims using a measures groups method:

Diabetes Mellitus Example

Primary care office visit for a new patient with newly diagnosed diabetes mellitus: A1c = lab drawn, result unknown, prior result not available (3046F-8P); LDL-C=110 (3049F); today's BP = 140/80 (3077F and 3079F); referred to eye care professional (optometrist or ophthalmologist) for dilated eye exam (2022F-8P); urine protein screening performed = negative (3061F); foot exam performed (2028F)

Table 8: Dx 1: 250.00

Measure Number	Date of Service	CPT/ HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
-	07/01/2008	99201			$60.00	123456789
-	07/01/2008	G8485			$0.00	123456789
-	07/01/2008	83036		1	$15.00	123456789
-	07/01/2008	81000		1	$6.00	123456789
1	07/01/2008	3046F	8P	1	$0.00	123456789
2	07/01/2008	3049F		1	$0.00	123456789
3	07/01/2008	3077F		1	$0.00	123456789
3	07/01/2008	3079F		1	$0.00	123456789
117	07/01/2008	2022F	8P	1	$0.00	123456789
119	07/01/2008	3061F		1	$0.00	123456789

Table 8 is an example of satisfactory reporting in PQRI. The eligible professional included G-code G8485 on the claim form to initiate reporting of the Diabetes Measures Group. In this example, the eligible professional has chosen to report Measures #1 and #117 with an 8P modifier indicating that performance of the measure was not met on this visit. An eligible professional may choose whether to report these two measures on the current claim or wait to report them on a claim for a subsequent visit during the reporting period after the results of the test/exam are available.

CKD Example

Stage 5 CKD patient, not receiving RRT, office visit: lab tests ordered on last visit and results documented in the chart (3278F); known hypertensive with documented plan of care for hypertension (G8477 and 0513F); Hgb = 14 and patient is receiving ESA and has a plan of care documented for elevated hemoglobin level (3279F and 0514F and 4171F); record indicates influenza immunization at a previous visit in January of this year (4037F); referred for AV fistula (4051F)

Table 9: Dx 1: 585.5; Dx 2: 401.0; Dx 3: 791.0

Measure Number	Date of Service	CPT/ HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
-	07/01/2008	99213		1	$50.00	123456789
-	07/01/2008	G8487		1	$0.00	123456789
121	07/01/2008	3278F		1	$0.00	123456789
122	07/01/2008	G8477		1	$0.00	123456789
122	07/01/2008	0513F		1	$0.00	123456789
123	07/01/2008	3279F		1	$0.00	123456789
123	07/01/2008	0514F		1	$0.00	123456789
123	07/01/2008	4171F		1	$0.00	123456789
135	07/01/2008	4037F		1	$0.00	123456789
153	07/01/2008	4051F		1	$0.00	123456789

Preventive Care Example

Primary care office visit for a 67 year old female, established patient presenting with mild cold symptoms. Record indicates patient had a DXA done at age 62, with results documented as within normal limits (G8399); denies urinary incontinence (1090F); record indicates influenza vaccination at a previous visit in January of this year (G8482); pneumonia vaccination administered last year (4040F); results of last month's mammogram (3014F) and last week's FOBT (3017F) reviewed with patient; denies tobacco use (1000F and 1036F and G8457); today's BMI measurement = 24 (G8420)

Table 10: Dx 1: Use any Visit-Specific Diagnosis for the Measures in this Group

Measure Number	Date of Service	CPT/ HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
-	07/01/2008	99212		1	$45.00	123456789
-	07/01/2008	G8486		1	$0.00	123456789
39	07/01/2008	G8399		1	$0.00	123456789
48	07/01/2008	1090F		1	$0.00	123456789
110	07/01/2008	G8482		1	$0.00	123456789
111	07/01/2008	4040F		1	$0.00	123456789
112	07/01/2008	3014F		1	$0.00	123456789
113	07/01/2008	3017F		1	$0.00	123456789
114	07/01/2008	1000F		1	$0.00	123456789
114	07/01/2008	1036F		1	$0.00	123456789
115	07/01/2008	G8457		1	$0.00	123456789
128	07/01/2008	G8420		1	$0.00	123456789

Rheumatoid Arthritis Example

Rheumatoid arthritis patient, office visit: prescribed DMARD therapy (4187F); documentation of TB screen performed and results interpreted two months ago (3455F and 4195F); disease activity assessed and documented as moderate (3471F); functional status assessed (1170F); disease prognosis assessed and documented as good (3476F); documented glucocorticoid use is for less than six months (4193F)

Table 11: Dx 1: 714.0

Measure Number	Date of Service	CPT/ HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
-	07/01/2008	99213		1	$50.00	123456789
-	07/01/2008	G8490		1	$0.00	123456789
108	07/01/2008	4187F		1	$0.00	123456789
176	07/01/2008	3455F		1	$0.00	123456789
176	07/01/2008	4195F		1	$0.00	123456789
177	07/01/2008	3471F		1	$0.00	123456789
178	07/01/2008	1170F		1	$0.00	123456789
179	07/01/2008	3476F		1	$0.00	123456789
180	07/01/2008	4193F		1	$0.00	123456789

Perioperative Care Example

Patient has surgery for resection of small intestine (Enterectomy): documentation of order for prophylactic antibiotic to be given within one hour prior to surgical incision (4047F); the order for the prophylactic antibiotic was for cefazolin (4041F); prophylactic antibiotics were given one hour prior to surgical incision and there is an order to discontinue within 24 hours of surgery end time (4049F and 4046F); documentation there was an order to give VTE prophylaxis within 24 hours of surgery end time (4044F)

Table 12: Dx 1: Use any Visit-Specific Diagnosis for the Measures in this Group

Measure Number	Date of Service	CPT/ HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
-	07/01/2008	44120		1	$1500.00	123456789
-	07/01/2008	G8492		1	$0.00	123456789
20	07/01/2008	4047F		1	$0.00	123456789
21	07/01/2008	4041F		1	$0.00	123456789
22	07/01/2008	4049F		1	$0.00	123456789
22	07/01/2008	4046F		1	$0.00	123456789
23	07/01/2008	4044F		1	$0.00	123456789

Back Pain Example

Initial office visit for a new patient with newly diagnosed back pain: back pain and function assessed including pain assessment, functional status, patient history with notation of no “red flags”, prior treatment and response assessment and employment status (1130F); physical exam performed (2040F); patient counseled to resume normal activities (4245F); patient advised against bed rest lasting four days or longer (4248F)

Table 13: Dx 1: 724.2

Measure Number	Date of Service	CPT/ HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
-	07/01/2008	99203		1	$60.00	123456789
-	07/01/2008	G8493		1	$0.00	123456789
148	07/01/2008	1130F		1	$0.00	123456789
149	07/01/2008	2040F		1	$0.00	123456789
150	07/01/2008	4245F		1	$0.00	123456789
151	07/01/2008	4248F		1	$0.00	123456789

Is there Additional Information on Reporting the Preventive Care Measures Group?

In January 2009, eligible professionals who wished to participate in PQRI using claims-based submission and had not yet participated in PQRI and submitted data to a registry, were provided the option to report on the Preventive Care Measures Group for 30 consecutive Medicare FFS patients between January 1, 2009 and December 31, 2009.

How to Start Using this Measures Group

- Select a start date to begin submitting quality data (e.g., February 15, 2009).
- Identify the next Medicare FFS patient seen who is 50 years of age or older and for whom an evaluation and management (E/M) code of 99201-99205 or 99212-99215 is billed. No specific diagnosis is required for this measures group. This is the first consecutive patient.
- Report the measures group specific G-code (G8486) with the first patient in the consecutive patient group.
- Look at Table 14 to see which measures apply to the patient based on their age and gender.

Table 14: Preventive Measures Group Demographic Criteria

Age	Measures for Male Patients	Measures for Female Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 114, 115, 128	110, 112, 113, 114, 115, 128
65-69 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 112, 113, 114, 115, 128
70-80 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 113, 114, 115, 128
>81 years	110, 111, 114, 115, 128	39, 48, 110, 111, 114, 115, 128

How to Report Using this Measures Group

- When the first patient is identified, place G-code G8486 on the claim to be submitted for that patient. This signals CMS that the intent is to submit the Preventive Care Measures Group on 30 consecutive Medicare FFS patients.
- Look at the **Data Collection Worksheet** (see Table 15). This worksheet includes a brief description of the measures in the Preventive Care Measures Group and the QDCs to report depending on the action or service provided to the patient. The appropriate QDCs for the measures that are reported for each patient will need to be included on a claim submitted for the patient during the 12-month reporting period. It is generally easier to report all of the applicable measures at one time on the same claim when the patient is seen in the consecutive patient sequence. However, if a particular service

has yet to be performed (e.g., a mammogram) and it is expected that the patient will be seen again before the end of the reporting period (December 31, 2009) at which time the patient will have had her mammogram, the mammography measure can be reported when the patient returns for her next visit later in the year.

New for 2009: If all quality actions for the patient have been performed for the group, G-code G8496 (All quality actions for the applicable measures in the Preventive Care Measures Group have been performed for this patient) may be reported in lieu of the individual QDCs for each of the measures within the group.

Check the 2009 PQRI Program section of the PQRI website for the full measures groups specifications at *http://www.cms.hhs.gov/PQRI* on the CMS website.

- Report **all** of the **applicable** measures (using the appropriate QDCs) on the claim submitted for each Medicare FFS patient. To help keep track, consider photocopying the **Data Collection Worksheet** (see Table 15) and highlighting or circling the appropriate measures (for the patient who is being seen) and the measure codes (QDCs) that needs to be submitted and then staple the worksheet to the superbill. The billing staff or company can use this information to report the appropriate measures codes on the patient's claim.
- Repeat this process 29 more times. Remember that the patients must be consecutive Medicare FFS patients. Medicare will determine the consecutive patient sequence by date of service on the claim submitted. Each patient counts as a unique patient. That is, there needs to be 30 different patients to qualify. The same patient cannot be counted twice even if they return the following day or week and the process of collecting and reporting on the 30 consecutive patients is still going on.

Note: The measures group specific G-code (G8486) does not need to be resubmitted on any patient after the first patient. Only report the QDCs for the measures that apply to the next 29 consecutive Medicare patients on each of those 29 patients' claim form.

Table 15: Data Collection Worksheet: PQRI Preventive Care Measure Group

Patient Name:	Date of Service:	Physician:	
Measure number and title*	**Action performed**	**Action not performed/Reason documented**	**Action not performed/ Reason not documented**
39: Screening or Therapy for Osteoporosis (females only)	**G8399** DXA ordered, documented or patient on Rx treatment	**G8401** DXA not ordered or patient not on meds for documented reason	**G8400** DXA not ordered No Rx treatment No reason noted
48: Assessment of Presence or Absence of Urinary Incontinence (females only)	**1090F** Incontinence assessed within past 12 months	**1090F-1P** Medical reason for not assessing incontinence	**1090F-8P** Not assessed No reason noted
110: Flu Vaccination (September through February)	**G8482** Vaccine ordered or given	**G8483** Vaccine not given for documented reason (e.g., wrong season)	**G8484** Vaccine not given No reason noted
111: Pneumonia Vaccination	**4040F** Vaccination given or previously received	**4040F-1P** Vaccine not given for medical reason	**4040F-8P** Vaccine not given or received No reason noted
112: Screening Mammography (females only)	**3014F** Results documented and received	**3014F-1P** Not performed for medical reason (e.g., mastectomy)	**3014F-8P** Not performed No reason noted
113: Colorectal Cancer Screening	**3017F** Screening done and results reviewed	**3017F-1P** Not done for medical reason	**3017F-8P** Not done No reason noted

Table 15: Data Collection Worksheet: PQRI Preventive Care Measures Group (continued)

Patient Name:	Date of Service:	Physician:	
Measure number and title*	**Action performed**	**Action not performed/Reason documented**	**Action not performed/ Reason not documented**
114: Inquiry Regarding Tobacco Use	**1000F** Tobacco use assessed **AND** either: **1034F** Current Smoker **OR** **1035F** Current Smokeless Tobacco **OR** **1036F** Current Non-smoker	Not applicable	**1000F-8P** Tobacco use not assessed No reason noted
115: Advising Smokers to Quit	**G8455** Smoker **AND** either: **4000F** Tobacco use cessation intervention, counseling **OR** **4001F** Tobacco use cessation intervention, pharmacologic therapy	**G8456** Smokeless Tobacco User **OR** **G8457** Tobacco Non-user	**G8455** Smoker **AND** **4000F-8P** Not counseled No reason noted

Table 15: Data Collection Worksheet: PQRI Preventive Care Measures Group (continued)

Patient Name:	Date of Service:	Physician:	
Measure number and title*	**Action performed**	**Action not performed/Reason documented**	**Action not performed/ Reason not documented**
128: Universal Weight Screening and Follow-Up	**G8420** BMI < 30 and ≥ 22 **OR** **G8417** BMI ≥ 30 with follow-up plan documented **OR** **G8418** BMI < 22 with follow-up plan documented	**G8422** Patient not eligible for BMI calculation	**G8421** BMI not calculated, no reason noted **OR** **G8419** BMI ≥ 30 or < 22 calculated but no follow-up plan documented

* Medicare coverage may differ from PQRI measures specification.

- Use the worksheet (see Table 16) to track each of the 30 consecutive patients. The measures which still need to be reported can be listed to help guide the patient's next visit. This worksheet is for the office's internal use only and should not be sent to CMS or the carrier/MAC.

Table 16: Worksheet to Track Consecutive Medicare FFS Patients for Reporting Preventive Care Measures Group

Consecutive Patient Number	Date of Service	Patient Identifier	All Applicable Measures Submitted for this Patient?	Measure Numbers that still need to be submitted for this Patient (if any)
Example A	02/15/2009	MS	No	112
Example B	02/16/2009	PF	Yes	None
1*				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
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28				
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30				

* When the first patient is identified, place G-code G8486 (in addition to QDCs) on the claim submitted for that patient. This signals CMS the intent is to submit the Preventive Care Measures Group on 30 consecutive Medicare FFS patients. The measures group specific G-code (G8486) does not need to be submitted on any patient after the first patient. Only report G8496 (all applicable quality actions for this patient have been performed) or the QDCs for the measures that apply to the next 29 consecutive Medicare patients on each of those 29 patients' claim form.

What are Some Tips for 2009 Successful Participation?

The following tips are offered to assist eligible professionals and office staff to submit PQRI measures accurately.

Claims-based Reporting of Individual Measures

- Ensure all staff understand the measures that have been selected to report. The primary authoritative sources for measure specifications are those posted on the CMS PQRI website.
- It is important to review **all** the denominator codes that can affect **claims-based** reporting, particularly for broadly applicable measures or measures that do not have an associated diagnosis (for example, #110 Influenza Immunization, #154 Falls Risk Assessment, #47 Advance Care Plan, etc.) because reporting on each eligible claim must be as instructed in the measure specifications.
- Ensure **all** eligible claims are identified and captured per the measure denominator for each measure selected. Note that several measures apply broadly across various settings of care (not only office practices but also hospitals, nursing homes, and home health agencies). For example, Table 17 shows some measures that include only CPT I service codes in the denominator; an ICD-9-CM diagnosis code is not required for denominator inclusion. Therefore, each individual eligible professional who chooses to report these broadly applicable measures will need to report the QDC on each eligible claim that falls into the denominator. Failure to submit a QDC on claims for these Medicare patients will result in a "missed" PQRI reporting opportunity that can impact incentive eligibility.

Table 17: Measures that include only CPT I service codes in the denominator

Measure Number	Measure Title	PQRI Reporting
47	Advance Care Plan	Report a minimum of **once** for all patients aged 65 years and older meeting denominator encounter codes.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Report a minimum of **once** for all patients aged 50 years and older meeting denominator encounter codes.

Table 17: Measures that include only CPT I service codes in the denominator (continued)

Measure Number	Measure Title	PQRI Reporting
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	Report a minimum of **once** for all patients aged 65 years and older meeting denominator encounter codes.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Report a minimum of **once** for all patients aged 18 years and older meeting denominator encounter codes.
130	Documentation and Verification of Current Medications in the Medical Record	Report at **each visit** for all patients aged 18 years and older meeting denominator encounter codes.

- For measures that require capturing clinical values for coding, make sure that these clinical values are available to those who are coding claims for PQRI reporting.
- Some measures have specified patient demographics, such as age parameters and sex, for denominator inclusion.
- For measures selected to report, carefully review all ICD-9-CM diagnoses (if applicable) and CPT service (encounter) codes that will qualify claims for inclusion in PQRI measurement calculations (i.e., claims that are denominator-eligible) to ensure that each claim includes the appropriate QDC(s) or QDC with the allowable CPT II modifier with the individual eligible professional's NPI. Refer to the 2009 PQRI Implementation Guide. If the diagnosis or encounter code is different than those listed in the PQRI denominator, then that measure will not apply.
- For measures that require more than one QDC (CPT II or G-code), please ensure that **all** codes are captured on the claim. For example, when submitting codes for Measure #3 - High Blood Pressure Control in Diabetes Mellitus, be sure to include codes for both the systolic and diastolic blood pressure. Refer to the CMS-1500 Claim Sample in Appendix D of the 2009 PQRI Implementation Guide.
- If all billable services on the claim are denied for payment by the carrier/MAC, the QDCs will not be included in PQRI analysis. The claim, as a whole, must include the payment codes, usually ICD-9-CM and CPT I or HCPCS codes, which supply the denominator as well as the QDCs, which supply the numerator in order for the measure's QDCs to be included in PQRI analysis. If the denied claim is subsequently corrected and paid through an adjustment, reopening, **or** the appeals process by the carrier/MAC, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on that corrected claim as instructed in the measure specifications. Note that claims may not be resubmitted only to add or correct QDCs, and claims with only QDCs on them with a zero total

dollar amount may not be resubmitted to the carrier/MAC. Remember that claim adjustments, reopenings, **or** appeals processed by the carrier/MAC must reach the national Medicare claims system data warehouse (NCH file) by February 28, 2010, to be included in the analysis.

- QDCs should be submitted on the line item of the claim as a zero charge or nominal amount such as a penny. The submitted charge field ($Charges) cannot be left blank. Since there is no allowed charge for the PQRI QDC line items, all PQRI QDC line items will be denied by the carrier/MAC claims processing system and passed onto the NCH file for PQRI analysis and incentive payment eligibility calculation. The Remittance Advice with denial code N365 is an indicator that the PQRI codes were passed into the NCH file for use in calculating incentive eligibility.

Note: Claims may **not** be resubmitted solely to add QDCs. Review the measure specification to determine the appropriate numerator codes to place on the claim. When applicable, utilize the 8P reporting modifier (or G-code equivalent) when the action required is not performed and the reason is not otherwise specified so that the claim will count toward satisfactory reporting.

- Check the Remittance Advice regularly to confirm the receipt of a remark code N365 for each QDC submitted to ensure that QDCs for individual measures as well as measures groups were passed into the NCH. This remark does not confirm QDC accuracy.

Claims-based Reporting of Measures Groups

There are two reporting methods for submission of measures groups that involve a patient sample selection: either the Consecutive Patient Sample Method or the 80 Percent Patient Sample Method. An "intent G-code" must be submitted for either method to initiate an eligible professional's intent to report measures groups via claims.

- When reporting quality actions for the PQRI measures groups, an individual eligible professional may report QDCs on each individual measure within the measures group **or** report one (composite) G-code, which indicates that all quality actions for all the measures in the group were performed (for example, G8494 indicates all quality actions for the applicable measures in the diabetes mellitus measures group have been performed for the patient).
- If all of the quality actions for the measures within the measures group were performed at an encounter during the reporting period, an eligible professional could report the composite G-code instead of reporting QDCs for each measure individually.

Note: Performance exclusion modifiers (i.e., 1P, 2P, 3P, or G-code equivalent) and the 8P reporting modifier cannot apply to the reporting of any measure within the measures group if the composite G-code is used for reporting because all of the quality actions for each measure must have been performed and documented. Refer to the CMS-1500 Claim Examples-Measures Groups under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website.

- For the consecutive patient sample method, "consecutive" refers to how the sample or cohort of patients eligible for a measures group was selected and consists of patients who were seen on consecutive dates of service by the eligible professional who has selected to report a measures group. If the patient selected in the sample returns at a subsequent encounter, a QDC may be added to that subsequent claim to indicate that the clinical action was performed during the reporting period. PQRI analysis will consider all QDCs submitted across multiple claims for patients in the consecutive sample.
- An eligible professional needs to only report the applicable measures for each patient that meets denominator inclusion in the consecutive patient sample. Denominator inclusion of the patient sample for both the Consecutive Patient Sample Method and the 80 Percent Patient Sample Method is determined by diagnosis and/or encounter parameters common to all measures within a selected measures group. For example, if patient #3 in the sample does not meet the age requirements for all of the measures within the measures group, report those measures that **are** applicable to patient #3. All patients may not meet all of the measure criteria within the measures group.
- An eligible professional who has contracted with an MA Plan should not include MA patients in **claims-based** reporting of measures groups using the Consecutive Patient Sample method. Only Medicare Part B FFS patients should be included in claims-based reporting of measures groups using the Consecutive Patient Sample Method.

Common Reporting Errors Associated with Claims-based Reporting

- No QDC submitted on an eligible claim. Failure to submit a QDC on claims for these Medicare patients will result in a "missed" PQRI reporting opportunity that can impact incentive eligibility.
- Eligible claim without an individual NPI or with the NPI incorrectly placed on the claim will result in a claim rejection by the carrier/MAC and will not be included in PQRI analysis.
- Eligible claim submitted as a QDC-only claim (no denominator information is accompanied).
- QDC submitted on a denominator-ineligible claim for the PQRI measure:
  - Diagnosis is incorrect on claim for measure reported;
  - Encounter code is incorrect on claim for measure reported; and
  - Age/gender on claim is incorrect for measure reported.
- Billing software does not allow enough lines on the claim and splits claim.

Registry-based Reporting of Individual Measures or Measures Groups

Submission of at least three individual measures or at least one measures group via registry is governed by the 2009 PQRI Quality Measures Specifications Manual and Release Notes and 2009 PQRI Measures Groups Specifications Manual, respectively. The qualified registry is responsible for providing their clients with instructions on how to submit the selected measures or measures group through the registry. Information

regarding qualified registries can be found under the 2009 PQRI Program section at *http://www.cms.hhs.gov/PQRI* on the CMS website.

Note: 18 PQRI measures and one measures group are reportable through the registry-based reporting option only.

Registry-based reporting for measures groups may include Medicare Part B FFS patients as well as non-Medicare patients when reporting using the Consecutive Patient Sample Method.

An eligible professional reporting measures groups via the Consecutive Patient Sample Method through the **registry** must report on all patients within the sample, regardless of payer.

Medical Record Documentation

An eligible professional should document fulfillment of measure requirements in the medical record.

Additional Resources

Additional references to assist eligible professionals in satisfactory PQRI reporting are located in Table 18.

Table 18: Additional References

CMS PQRI Tip Sheet References	CMS/PQRI Website Location
2009 PQRI Fact Sheet: What's New for the 2009 PQRI	*2009 PQRI Program section*
Eligible Professionals List	*Eligible Professionals Download*
2009 PQRI Implementation Guide Appendix A: Glossary of Terms Appendix B: Sample 2009 PQRI Measure Appendix C: 2009 PQRI Participation Decision Tree Appendix D: CMS-1500 Claim Example	*2009 PQRI Program section*
2009 PQRI Quality Measures List	*2009 PQRI Program section*
2009 PQRI Quality Measures Specifications Manual and Release Notes	*2009 PQRI Program section*
2009 PQRI Measures Groups Specifications Manual	*2009 PQRI Program section*
Getting Started with 2009 PQRI Reporting of Measures Group	*2009 PQRI Program section*
CMS-1500 Claim Examples-Measures Groups	*2009 PQRI Program section*

Table 18: Additional References (continued)

CMS PQRI Tip Sheet References	CMS/PQRI Website Location
2009 PQRI Tip Sheet: PQRI Made Simple-Reporting Preventive Care Measures Group	*2009 PQRI Program section*
2009 PQRI Patient-Level Measures List	*2009 PQRI Program section*
Information and Materials for National Provider Calls & Open Door Forums	*CMS Sponsored Calls web page*
FAQs	*PQRI FAQs - Related Links Inside CMS, bottom of PQRI web page*

Appendix 1

2008 PQRI Measures Removed for 2009

2008 PQRI Measures Removed for 2009

Measure Number	Measure Title
4	Screening for Future Fall Risk
73	Plan for Chemotherapy Documented Before Chemotherapy Administered
74	Radiation Therapy Recommended for Invasive Breast Cancer Patients who have Undergone Breast Conserving Surgery
75	Prevention of Ventilator-Associated Pneumonia – Head Elevation
77	Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD
78	Vascular Access for Patients Undergoing Hemodialysis
80	Plan of Care for ESRD Patients with Anemia
88	Hepatitis A and B Vaccination in Patients with HCV
96	Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use
97	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use
98	Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use
101	Appropriate Initial Evaluation of Patients with Prostate Cancer
103	Review of Treatment Options in Patients with Clinically Localized Prostate Cancer
120	ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD
125	HIT – Adoption/Use of e-Prescribing
129	Universal Influenza Vaccine Screening and Counseling
132	Patient Co-Development of Treatment Plan/Plan of Care
133	Screening for Cognitive Impairment

Appendix 2

New PQRI Measures for 2009

New PQRI Measures for 2009

Measure Number	Measure Title	Measure Source
135	Chronic Kidney Disease (CKD): Influenza Immunization	American Medical Association – Physician Consortium for Performance Improvement (AMA-PCPI)
136	Melanoma: Follow-Up Aspects of Care	AMA-PCPI/ National Committee for Quality Assurance (NCQA)
137	Melanoma: Continuity of Care – Recall System	AMA-PCPI/NCQA
138	Melanoma: Coordination of Care	AMA-PCPI/NCQA
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	AMA-PCPI/NCQA
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	AMA-PCPI/NCQA
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	AMA-PCPI/NCQA
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	AMA-PCPI
143	Oncology: Medical and Radiation – Pain Intensity Quantified	AMA-PCPI
144	Oncology: Medical and Radiation – Plan of Care for Pain	AMA-PCPI
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	AMA-PCPI/NCQA

New PQRI Measures for 2009 (continued)

Measure Number	Measure Title	Measure Source
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	AMA-PCPI
147	Nuclear Medicine: Correlation with Existing Imaging Studies for all Patients Undergoing Bone Scintigraphy	AMA-PCPI
148*	Back Pain: Initial Visit	Back Pain: Initial Visit
149*	Back Pain: Physical Exam	NCQA
150*	Back Pain: Advice for Normal Activities	NCQA
151*	Back Pain: Advice Against Bed Rest	NCQA
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD	AMA-PCPI
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA-PCPI
154	Falls: Risk Assessment	AMA-PCPI
155	Falls: Plan of Care	AMA-PCPI
156	Oncology: Radiation Dose Limits to Normal Tissues	AMA-PCPI
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection	Society of Thoracic Surgeons (STS)
158	Endarterectomy: Use of Patch During Conventional Endarterectomy	STS
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA-PCPI/NCQA
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	AMA-PCPI/NCQA
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	AMA-PCPI/NCQA
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	AMA-PCPI/NCQA
163	Diabetes Mellitus: Foot Exam	NCQA
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	STS
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	STS
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	STS

New PQRI Measures for 2009 (continued)

Measure Number	Measure Title	Measure Source
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	STS
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	STS
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	STS
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	STS
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	STS
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	Society for Vascular Surgery (SVS)
173	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	AMA-PCPI
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis	AMA-PCPI
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization	AMA-PCPI
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AMA-PCPI/NCQA
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AMA-PCPI/NCQA
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AMA-PCPI/NCQA
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AMA-PCPI/NCQA
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AMA-PCPI/NCQA
181	Elder Maltreatment Screen and Follow-Up Plan	Quality Insights of Pennsylvania (QIP)/CMS
182	Functional Outcome Assessment in Chiropractic Care	QIP/CMS
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	AMA-PCPI
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	AMA-PCPI

New PQRI Measures for 2009 (continued)

Measure Number	Measure Title	Measure Source
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	AMA-PCPI/NCQA
186	Wound Care: Use of Compression System in Patients with Venous Ulcers	AMA-PCPI/NCQA

* These measures are reportable solely as part of the Back Pain Measures Group and not as individual quality measures.

Appendix 3

2009 Registry-only PQRI Measures

2009 Registry-only PQRI Measures

Measure Number	Measure Title	Measure Source
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	AMA-PCPI
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	AMA-PCPI/NCQA
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	AMA-PCPI/NCQA
81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients	AMA-PCPI
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis	AMA-PCPI
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA-PCPI/NCQA
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	AMA-PCPI/NCQA
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	AMA-PCPI/NCQA
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	AMA-PCPI/NCQA
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	STS
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	STS
166	Coronary Artery Bypass Graft (CABG): Stroke/ Cerebrovascular Accident (CVA)	STS
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	STS
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	STS
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	STS

2009 Registry-only PQRI Measures (continued)

Measure Number	Measure Title	Measure Source
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	STS
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	STS
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis	AMA-PCPI

Appendix 4

2009 PQRI Measures Groups

Table 1: 2009 Diabetes Mellitus Measures Group

Measure Number	Measure Title	Measure Source
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA
163*	Diabetes Mellitus: Foot Exam	NCQA

* New measure added to this measures group for 2009 is denoted with an asterisk.

Table 2: 2009 Chronic Kidney Disease (CKD) Measures Group

Measure Number	Measure Title	Measure Source
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	AMA-PCPI
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AMA-PCPI
123	Chronic Kidney Disease (CKD): Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)	AMA-PCPI
135*	Chronic Kidney Disease (CKD): Influenza Immunization	AMA-PCPI
153*	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA-PCPI

* New measures added to this measures group for 2009 are denoted with an asterisk.

Measure # 120 – ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with Chronic Kidney Disease (CKD) has been removed from the CKD Measures Group for 2009.

Table 3: 2009 Preventive Care Measures Group

Measure Number	Measure Title	Measure Source
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA-PCPI/NCQA
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA
112	Preventive Care and Screening: Screening Mammography	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers to Quit	NCQA
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	QIP/CMS

Table 4: 2009 Rheumatoid Arthritis Measures Group

Measure Number	Measure Title	Measure Source
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	NCQA
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AMA-PCPI/NCQA
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AMA-PCPI/NCQA
178	Rheumatoid Arthritis (RA): Functional Status Assess	AMA-PCPI/NCQA
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AMA-PCPI/NCQA

Table 4: 2009 Rheumatoid Arthritis Measures Group (continued)

Measure Number	Measure Title	Measure Source
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AMA-PCPI/NCQA

Table 5: 2009 CABG Measures Group (reportable only through a qualified PQRI registry)

Measure Number	Measure Title	Measure Source
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	STS
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	STS
164*	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	STS
165*	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	STS
166*	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	STS
167*	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	STS
168*	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	STS
169*	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	STS
170*	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	STS
171*	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	STS

* This measure is reportable only via registry-based reporting and is not reportable via claims- based reporting.

Table 6: 2009 Perioperative Care Measures Group

Measure Number	Measure Title	Measure Source
20	Perioperative Care: Timing of Antibiotic Prophylaxis - Ordering Physician	AMA-PCPI/NCQA
21	Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin	AMA-PCPI/NCQA
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	AMA-PCPI/NCQA
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	AMA-PCPI/NCQA

Table 7: 2009 Back Pain Measures Group

Measure Number	Measure Title	Measure Source
148	Back Pain: Initial Visit	NCQA
149	Back Pain: Physical Exam	NCQA
150	Back Pain: Advice for Normal Activities	NCQA
151	Back Pain: Advice Against Bed Rest	NCQA

The measures in the Back Pain Measures Group are reportable only as a measures group and not as individual measures.

January 2010
ICN 903204